2006/016

PRINTED: 05/14/2018 FORM APPROVED

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OMB NO. 0938-0391 (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION

		(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIP A. BUILDING	LE CONSTRUCTION	COMPLETED
Pr	1#1	445342	B, WING		05/10/2018
NAME OF PROVIDER OR SUPPLIER WESTMORELAND CARE & REHAB CTR				STREET ADDRESS, CITY, STATE, ZIP CODE 1559 NEW HIGHWAY 52 WESTMORELAND; TN 37186	
(X4) ID PREFIX TAG	(FACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING (NFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROF DEFICIENCY)	D BE COMPLETION
F 000 F 686 SS=D	6/10/18 at Westmon Center. Deficeincier recertification surver related to complaint 42 CFR PART 483, Care Facilities. Treatment/Svcs to I CFR(s): 483.25(b)(1) §483.25(b) Skin Integration of the compression of the compressional standar pressure ulcers and ulcers unless the indemonstrates that to the facility professional standar pressure ulcers and ulcers unless the indemonstrates that to the facility professional standar pressure ulcers and ulcers unless the indemonstrates that to the facility professional standar pressure ulcers and ulcers unless the indemonstrates that to the facility professional standar pressure ulcers and ulcers from detailing, professional standard pressure ulcers from details promote healing, professional standard interview, the facility of the fac	rvey and complaint 7 were completed on 5/8/18 to reland Care and Rehab 5 were cited related to the 6 y. No deficiencies were cited 6 investigation #44227 under 7 Requirements for Long Term 8 Prevent/Heal Pressure Ulcer 11)(1)(1)(1) 9 grity 9 sure ulcers. 12 rehensive assessment of a 13 must ensure that- 14 es care, consistent with 15 rdoes not develop pressure 16 dividual's clinical condition 17 hey were unavoidable, and 18 ressure ulcers receives 18 and services, consistent 18 and services, consistent 19 event infection and prevent 10 event infection and prevent 11 event infection and prevent 12 event infection and prevent 13 event infection and prevent 14 event infection and prevent 15 event infection and prevent 16 event infection and prevent 17 event infection and prevent 18 event infection and prevent 19 event infection and prevent 10 event infection and pr	F 686	not believe and does not admit that any deficiencies existed, before, during or af survey. The Facility reserves all rights to contest the survey findings through info dispute resolution, formal appeal proceed or any administrative or legal proceeding plan of correction is not meant to establistandard of care, contract obligation or position and the Facility reserves all right raise all possible contentions an defense any type of civil or criminal claim, action proceeding. Nothing contained in this plus correction should be considered as a way any potentially applicable Peer Review, Assurance or self critical examination promited the Facility does not waive and rethe right to assert in any administrative, criminal claim, action or proceeding. The facility offers its responses, credible allegof compliance as part of its ongoing effor provide quality of care to residents. Corrective Action for Residents Affected: 1. The clinical record for Elder #73 was immediately reviewed by the DON a Wound Care Nurse on 5/8/18 to concurrent orders for floating of the Eld #73 heels. In-servicing was complete on 5/10/18 by Staff Development Coordinator with LPN #1 and RN #1 proper positioning needed for floating the heels of the resident. All available C.N.A.'s were also in-serviced by the Staff Development Coordinator on 5/10/18 on the correct position for floating the heels of a resident.	rmal edings gs. This ish any ts to es in or an of iver of Quality ivilege serves civil or e gations rts to 5/10/18 nd of irm er ed on ng e
-4	7 UUU 11KK	SORILO LINHA	5	191/18	

2/1/18 Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

> If continuation sheet Page 1 of 4 faxrecicl 5:22:18

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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CENTERS FOR MEDICARE		(X1) PROVIDER/SUPPLIER/GLIA	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
AND PLAN OF CORRECTION		IDENTIFICATION NUMBER	A. BUILDING		Com LL Ida		
		445342	B. WING			05/	10/2018
NAME OF PROVIDER OR SUPPLIER WESTMORELAND CARE & REHAB CTR			×	16	TREET ADDRESS, CITY, STATE, ZIP CODE 569 NEW HIGHWAY 52 /ESTMORELAND, TN 37186		(X6) COMPLETION
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			PREFIX PRECEDED BY FULL PREFIX (EACH CORRECTION ADDRESS OF THE ADD			
F 686	including Diarrhea, Seizures, Anemia, Muscle Weakness, Fibrillation. Medical record revi Data Set (MDS) for revealed the reside	Adult Failure to Thrive, Chronic Pain Syndrome, and Peroxysmal Atrial ew of the Admission Minimum Resident #73 dated 4/17/18 nt had a Brief Interview for S) score of 6 indicating	F 6	86	Potential Residents Affected: 2. A review of all current residents tha require their heels to be floated will be performed by the DON, ADON, Unit Manager, Wound Care Nurse, MDS Coordinators, and/or Administrator by 5/18/18. All residents that require the heels to be floated will have their currell plan of care updated to reflect the curneeds to the elder. The Nursing staff when the made aware of the current elders the require their heels to be floated by the ADON and Unit Manager by 5/18/18.	e ir ent rent vill	5/18/18
NI 1 MT	Medical record revi Orders for Residen "Heel floats to bla Medical record revi for Resident #73 da	ew of Physician Telephone t #73 dated 4/18/18 revealed ateral heels while in bed" ew of the Physicians orders ated May 2018 revealed ateral heels while in bed"			Systematic Measures: 3. An in-service was completed for the alleged deficient practice by the Staff Development Coordinator on 5/10/18. follow up in-service will be conducted 5/31/18 by the Staff Development Coordinator to prevent future occurred Monitoring Changes:	. A by	5/31/18
8	Record (TAR) for F through 5-31-18 re- bilateral heels while Observation of Res AM and again at 8: revealed the reside	he Treatment Administration desident #73 dated 5-1-18 vealed "Heel floats to a in bed" sident #73 on 5/9/18 at 7:27 17 AM in the resident's room int lying in bed with his feet ar the cover and no heel floats		T1	4. The DON, ADON, Unit Manager, Administrator, Weekend Manager, and Wound Care Nurse will monitor for compliance daily for four weeks beging 5/21/18, then once a week for four we and monthly thereafter until substanticompliance is achieved. All audit findir will be brought to the QAPI Meeting for review, trending, and planning monthly three months.	ning eeks, al ags	6/4/18
£ 5	on 5/8/18 at 3:25 P revealed Resident: Tissue Injury (SDT) stated "he has he Interview with Regil 6/9/18 at 1:49 PM i	nsed Practical Nurse (LPN) #1 M in the common area room #73 had a Suspected Deep I) to his right heel and she rel floats when he's in bed" stered Nurse (RN) #1 on In the Willow Brook nurses e expected heel floats to be	ř	20.00	3		

DEPARTMENT OF HEALTH AND HUMAN SERVICES
CENTERS FOR MEDICARE & MEDICAID SERVICES

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CENTERS FOR MEDICARE & MEDICARD SERVICES		(X2) MULTIPLE CONSTRUCTION				(X3) DATE SURVEY	
TATEMENT OF DEFICIENCIES (XI) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		A. BUILDING				COMPLETED	
		445342	B. WING			05/	10/2018
NAME OF PROVIDER OR SUPPLIER WESTMORELAND CARE & REHABICTR				1689 N	T ADDRESS, CITY, STATE, ZIP CODE NEW HIGHWAY 52 IMORELAND, TN 37186		W. 4 2 2
(X4) ID PREFIX TAG	PREFIX (EACH DEFICIENCY MUST BE PREDEDED BY FOLL		SUMMARY STATEMENT OF DEFICIENCIES ID PROVIDER'S PLAN OF CORRECT (FACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOW)		PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROPE DEFICIENCY)	BE	COMPLETION DATE
F 686 F 812 SS¤F	placed on residents wouldn't do them at them on in bed, that them" Food Procurement CFR(s): 483.60(i)(1) §483.60(i) Food sa The facility must - §483.60(i)(1) - Procuperoved or considerate or local author (I) This may include from local produced and local laws or ref (ii) This provision of facilities from using gardens, subject to safe growing and for (iii) This provision of from consuming for \$483.60(i)(2) - Stores	s when in bed, he stated "It ny good if they didn't have ut's supposed to help protect (Store/Prepare/Serve-Sanitary (2) Store/Prepare/Serve-Sanitary (2) Sety requirements. Sure food from sources dered satisfactory by federal, rities. It food items obtained directly resultions. Set subject to applicable State agulations. Soes not prohibit or prevent a produce grown in facility compliance with applicable bood-handling practices. Soes not preclude residents ods not procured by the facility.	F6	12	Corrective Action for Residents Affects 1. No Elders were identified in this cita Upon identification, this was immed corrected by the Dietary Manager at Kitchen staff on 5/8/18. The Dietary Manager educated available dietary on maintaining dietary equipment in sanitary manner. Potential Elders Affected: 2. The Dietitian re-educated the Dietar Department on 5/17/18 on the importance of preparing, distributin serving food in a safe and sanitary environment. The Dietitian also stre the importance of maintaining dieta equipment in a sanitary manner. Fur monitoring has confirmed that this practice has not been deficient. Systematic Changes: 3. A new mixer was ordered and arrive 5/21/18. The Dietary Manager and/or street in the st	etion. liately nd staff n a g, and ssed ary rther	5/8/18 5/17/18
	standards for food This REQUIREMED by: Based on observationation of the standard of the servations. Findings include: Observation on 5/8 12:00 PM, at 1:53 F	dance with professional service safety. NT is not met as evidenced tion and interview, the facility failed to maintain dietary itary manner in 2 of 5 /18 between 11:53 AM to PM, and 2:25 PM, with the anager (CDM) present,		4	Cook will complete audits of sanitati the kitchen daily for 4 weeks beginn 5/24/18, 3 times a week for 4 weeks 2 times a month for 2 months until substantial compliance is achieved. Monitoring Changes: The Dietary Manager, Dietitian and Administrator are responsible for compliance. The Dietary Manager w review the audit findings weekly and report the audit findings to the QAP Committee monthly for 6 months.	ion in ing on a s, and ill d will	6/4/18

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

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STATEMENT AND PLAN O	OF DEFICIENCIES F CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION A. BUILDING			(X3) DATE SURVEY COMPLETED	
3,0		445342	B, WING		05/1	0/2018	
NAME OF PROVIDER OR SUPPLIER WESTMORELAND CARE & REHAB CTR				STREET ADDRESS, CITY, STATE, ZIP CODE 1559 NEW HIGHWAY 52 WESTMORELAND, TN 37186			
(X4) ID PREFIX TAG	(EACH DEFICIENC)	TEMENT OF DEFICIENCIES Y MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTIO (EACH CORRECTIVE ACTION SHOULD CROSS-REFERENCED TO THE APPROP DEFICIENCY)	BE	(X5) COMPLETION DATE	
F 812	various colored drie the beater arm and had dried accumula around the 3 conne observation reveale oven interior had a blackened debris. I walk-in freezer revealed blade had an adebris. Interview with the Cand 1:55 PM in the the floor mixer, starwalk-in freezer connot maintained in a Observation on 6/8 department dish rorevealed the dish in Further observation multiple racks with washed, air dried, a observation positione machine. Further owas in operation arthe dish machine, toleaned dishes. Interview with the Cand dietary department of the dietary department of the dietary department dish the Cand dietary department dish machine, toleaned dishes.	nixer had multiple splatters of ad debris on the underside of the mixer bowl holder arms ation of brown colored debris action sites to the bowl. Further ed the stacked convection heavy accumulation of further observation in the ealed the condenser fan grate accumulation of blackened. CDM on 6/8/18 at 12:00 PM dietary department confirmed eked convection oven, and the denser grate and blades were sanitary manner. /18 at 2:25 PM in the dietary om, with the CDM present, nachine was in operation. In revealed silverware and dishes and mugs had been and stored. Further ed a wall mounted fan in d on the dirty side of the dish bservation revealed the fan and directed at the dirty side of therefore contaminating the company of the fan and directed at the dirty side of the fan and directed at the directed a	F 812				
	in a	E		V south		Dage A of A	

PRINTED: 05/10/2018 DEPARTMENT OF HEALTH AND HUMAN SERVICES FORM APPROVED OMB NO. 0938-0391 CENTERS FOR MEDICARE & MEDICAID SERVICES (X3) DATE SURVEY (X2) MULTIPLE CONSTRUCTION STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CLIA COMPLETED IDENTIFICATION NUMBER: A. BUILDING. 05/10/201B B, WING 445342 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 1559 NEW HIGHWAY 52 WESTMORELAND CARE & REHAB CTR WESTMORELAND, TN 37186 PROVIDER'S PLAN OF CORRECTION (X5) COMPLETION DATE SUMMARY STATEMENT OF DEFICIENCIES (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE (X4) ID PREFIX PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) E 000 Initial Comments E 000 An emergency preparedness survey was completed on 5/8/18 to 5/10/18 at Westmoreland Care and Rehab Center. No Deficiencies were cited under FED-E-1.00.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

TITLE

(XB) DATE

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